



INDIVIDUAL
HEALTH PLAN
BROKER MANUAL

April 2011

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OPTIMA INDIVIDUAL HEALTH PLAN BROKER MANUAL
Designed for Optima Health Agents

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1- Introduction- Optima Health Individual Product

This manual provides information on how we address some of the more common underwriting subjects. Pre-Medicare eligible benefits and our underwriting practices and principles are described in the manual. We will continue to update this document to provide users with the most up-to-date information available.

2- Contact Information

Sales: IndividualSales@sentara.com
Fax: (877) 388-3814

Underwriting: Individualuw@sentara.com
Fax: (757) 552-8905

Where to send Applications: IndividualSales@sentara.com
Fax: (877) 388-3814
Mail: Optima Health
4417 Corporation Lane
Virginia Beach, Va 23462
Attn: Individual Underwriting

*Brokers working with a GA must submit applications through their Optima Health GA representative. Applications sent direct will be returned to the appropriate GA.

Member Services: (757) 552-7274 or (866) 514-5916

Broker Services: (866) 927-4785

Web site: www.OptimaHealth.com

3- Broker Individual Web site – Quotes, Application, and Status Updates

Before an agent can write business with the Optima Health individual and family health plans, the agent must be appointed with Optima Health and must request individual authorization. Ask your representative for the Individual Authorization Form so we can set up your Individual Broker Portal. From the broker portal, you can easily manage new and existing clients at any time of the day. Broker portal functions include:

- **Quotes:** Agents are responsible for their own quotes. Proposals can be generated online and sent directly to your clients.
- **Applications:** Applications can be completed 3 ways:
 - a. Electronic – Broker can set up a new application in minutes and send to your client electronically. Signature is electronic and your client can submit directly to underwriting.

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- b. Web link – Optima Health will assign a unique URL link to each broker. Prospects who enter that link are instantly launched to an application that is hosted by the broker. The URL link can either be posted on a Web site or embedded into a personal email.
- c. Paper – You can also print a paper application directly from Web site. As a broker, you can submit the completed paper application directly through the Web site (fastest method) or mail, fax or email it to your Optima Health representative.
- **Case Updates:** Updates for new and existing cases are attached to each Case Summary. Secure communication between client, broker, underwriting and sales is permanently attached to your cases when using the Application Summary Notes and Messages function. For assistance or training, please call individual sales at (866) 927-4785.
- **Policy Changes:** Through the broker portal, brokers can submit policy changes on behalf of their clients at any time.
- **Approved Applications:** Applications approved by Underwriting without being rated up will be automatically enrolled. Applications approved by Underwriting with a rate up or with a change in effective date, will have to be accepted by the Applicant before they are enrolled.

Payment

Except for the initial payment, all ongoing payments must be set up on automatic draft from a personal checking account. Drafts will occur between the 5th and 8th day of each month.

- Initial Payment – Payment will not be processed until policy is issued.
 - a. Online Application: Initial payment must be with a personal credit card – Visa or MasterCard only.
 - b. Mailed Application: Initial payment can be made by Visa, MasterCard, personal check, credit card, or certified funds.

Member Online Services

Members can register online and access their account, policy and claims information at anytime. From their online site they can update their policy information, make plan changes and add/delete dependants. Brokers, encourage your clients to register at: optimahealth.com, then select Members for easy registration.

4- Tips for Completing an Application

Failure to complete a health insurance application may cause delays in processing. Please verify the following items are completed before submitting your client's application:

- All demographic questions have been answered completely
- Effective date has been selected.
- Coverage Plan has been selected including rider if applicable.
- Make sure that they check yes or no if they would like any of the riders offered

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- All medical questions are filled out completely.
- Medical treatment history section is filled out completely. This can speed up the application process,
- All payment information is filled out completely.
- The applicant and agent have signed and dated the application.(Dependents 18 years of age or older also need to sign and date the application.)
- If information is missing, we will send a letter indicating what is needed. If the missing information is not provided within 15 days the application will be returned.

5- What Eligibility Means

To be eligible for coverage with Optima Health (between birth and age 65) you must reside in our service area. The policy specifies that those individuals eligible for coverage are you; your legal spouse; your natural, legally adopted, or step children under age 26; your children under age 26 placed with you for adoption; other children under age 26 in your legal custody.

Who is not eligible for coverage with Optima Health? An individual who is age 65 or older, who is eligible for coverage through any social welfare program (except Medicaid), who is a foster child or any person who is the primary subscriber under any Optima Health plan or Optima Health Insurance employer group plan, is not eligible for coverage.

6- Disenrollment of Ineligible Subscribers and Dependents

A. Should the Plan discover at any time that the applicant or their dependents are not eligible for coverage; were never eligible to be enrolled for coverage; and/or submitted false proof of eligibility for coverage, then the Plan may, at its sole discretion either:

1. Retain the premium paid up to the date the plan became aware of the ineligibility. Coverage will be canceled after the date through which premiums were paid; or
2. Refund the premium payment made during the period of ineligibility to you. You and/or your dependents will be disenrolled. The Plan may retract all or part of any claims paid from the provider(s) during the period of ineligibility. Disenrollment may result in the reversal and/or denial of claims during the period of ineligibility. You may be held responsible for any charges for claims for services received during the period of ineligibility.

B. Individual Product members requesting to terminate coverage will be terminated effective upon notification of the intent to cancel or on a later date specified by the member. If no date it is specified, they will be terminated at the end of the month in which they made the request. If the policy is cancelled, Optima Health will promptly return the unearned portion of any premium paid. The earned premium will be computed pro rata. Cancellation will be without prejudice to any claim originating prior to

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the effective date of cancellation. All requests for disenrollment / cancellation must be submitted to Optima Health in writing.

7- Who is the Primary Applicant?

The individual applying for the policy is called the primary applicant. This individual must have the legal capacity to contract and be recognized by the Commonwealth as the person who becomes the policyholder or policy-owner and be over the age of 18. Child only applications are not allowed.

8- Who is a Dependent?

A dependent is any person who is a member of a subscriber's family, meets all applicable eligibility requirements of the policy, is enrolled pursuant to the policy, and for whom the required fees have been received by the Plan.

A dependent is a spouse and children of the applicant. Children are defined as a natural child, adopted child, stepchild, or other child (grandchild) for whom the applicant or applicant's spouse is legally responsible (except a foster child). Child includes the insured's mentally or physically handicapped child, who, as a result of the disability, is unable to perform self-support. It is not mandatory that the child reside with the applicant.

9- Newborn and Adoption Rules

The parent or legal guardian of any child that is age six months or less when the application is signed is required to complete a newborn questionnaire and have had their first well-baby visit. The questionnaire is usually completed over the telephone. During the questionnaire a professional insurance interviewer will obtain basic medical information about the child. This information is required due to the age of the child. The process lasts approximately ten minutes. The applicant should have the names, addresses and phone numbers of the child's pediatrician, past medical treatments including dates, current medications and dosage amounts and other questions pertaining to insurability. Under a plan that provides coverage for a family member of the Subscriber, a newborn child of the Subscriber or an insured will be covered from the moment of birth for 31 days. An adopted child whose placement has occurred within 31 days of birth will be considered a newborn child of the Subscriber as of the date of adoptive or parental placement. The newborn child's coverage will be identical to coverage provided to the Subscriber.

In order for coverage to continue beyond the first 31 days, the subscriber must add the newborn to the Plan and submit any required premiums within 31 days of the newborn's birth. Adopted children will be eligible for coverage from the date of placement with the Subscriber. An adopted child that is placed within 31 days of birth will be considered a newborn child of the Subscriber as of the date of placement. The Subscriber must add

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the adopted child to the plan and submit evidence of placement and any applicable premiums within 31 days from the date of placement. If an enrollment application and any required premiums are not submitted within 31 days of a qualifying event, (such as the birth, adoption or placement for adoption), the newborn, the adopted child, or other dependent will not be automatically eligible for enrollment under the Subscriber's current Policy and is subject to all the Plan's application and underwriting requirements.

10- Dependent Children's Right of Conversion to New Policy

Dependent children may enroll separately in the same plan as their parents without current evidence of insurability; subject to and limited to election of the same deductible, coinsurance option, and out-of-pocket maximums. Optima Health will apply time credit earned by the dependent child on the parent's policy toward the new policy's waiting period for past or present health conditions, also subject and limited to dependents who previously maintained (in their parent's policy) continuous coverage without a 63-day break of coverage. If there is a break of coverage, the dependent child may be subjected to new evidence of insurability and be required to begin a new waiting period for past or present health factors (medical conditions). Please keep in mind whenever Optima Health is posed with taking on additional risk or asked to provide richer benefits, medical evidence of insurability is required unless there is an existing exception that the underwriting guidelines specifically provide.

11- Child Only Application

Child only applications are not allowed.

12- When Does Coverage End for Children?

- Dependent coverage **ends on the last day of the month they reach age 26** for covered children.
- **Dependent handicapped children** who are both incapable of self-sustaining employment by reason of mental or physical disability and who chiefly are dependent upon the subscriber for support and maintenance **will continue to be eligible for coverage beyond the plan's limiting ages**. You must give the plan acceptable proof of incapacity and dependency within 31 days of the child's reaching the specified age. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other physician stating the dependent is incapable of self-sustaining employment by reason of mental or physical disability.

13- Service Area Means What to Me?

The service area is the designated geographic area in which the plan will arrange for the provision of Health services. It consists of counties and cities.

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The counties are as follows:

Accomack, Albemarle, Amelia, Augusta, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Clarke, Culpeper, Cumberland, Dinwiddie, Essex, Fauquier, Fluvanna, Frederick, Gloucester, Goochland, Greene, Greenville, Hanover, Harrisonburg, Henrico, Isle of Wight, James City, King George, King & Queen, King William, Lancaster, Loudon, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Powhatan, Prince Edward, Prince George, Rappahannock, Richmond, Rockingham, Shenandoah, Southampton, Spotsylvania, Stafford, Surry, Sussex, Warren, Westmoreland, and York.

The cities are as follows:

Charlottesville, Chesapeake, Colonial Heights, Emporia, Farmville, Fredericksburg, Franklin, Hampton, Hopewell, Newport News, Norfolk, Petersburg, Portsmouth, Poquoson, Richmond, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg, and Winchester.

In order for an individual to purchase and maintain Optima Health's individual product, the applicant and all family members requesting coverage must reside in Optima Health's service area. This requirement is also true for HIPAA eligible individuals. Members who move out of the service area are allowed six months to move back into the service area or they will be disenrolled.

14- Currently an Optima Health Member But Want An Individual Policy?

An employee covered or eligible to be covered by Optima Health group coverage is not eligible for an Optima Health individual policy. **However**, his or her spouse and dependents may be eligible to apply for an Optima Health individual policy.

15- Currently Have an Individual Policy with Another Carrier?

Individuals and/or a family covered under another individual policy may apply for coverage as long as their intent is to replace current coverage. Individuals seeking to change carriers should NOT cancel their current coverage until obtaining Optima Health approval of their new coverage.

16- Non-USA Citizenship Rules

Optima Health will give individual consideration to eligible non-U.S.A. citizens applying for our individual plan on a paramedical exam requirement qualifying basis only. Any individual that is not a US citizen but has resided in the US for at least **two consecutive years**, while on a full-time work or student visa, is required to obtain a paramedical

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examination to include blood and urine testing for **consideration** of any coverage. Proof of residency will be required. **Non-citizen individuals who have resided in the US for less than two years will not be considered for coverage.** Other additional requirements may be required and requested by underwriting. Acceptance of any applicant in this category is at the sole discretion of underwriting and is selectively made to produce expected results.

17- When Coverage Becomes Effective

A coverage effective date is assigned upon approval. The effective date must be within 75 days of the applicant's signature date. The effective date for all new business will be the 1st of the month or the 15th of the month. The application must be received before the requested effective date. However, Underwriting reserves the right to change the effective date at their discretion. Therefore, the policyholder may receive their policy with an effective date that is advanced in the future. When assigning a policy effective date, we will be sensitive to breaks in coverage.

18- Underwriting Requirements

The following is our general underwriting requirements guideline for new business. This list is subject to change at the discretion of the underwriting department.

AGE	REQUIREMENT*
0-6 MOS	Telephone Interview Required Attending Physician Statement - Underwriter's Discretion
>6 MOS-44 with no current coverage	Telephone Interview – Required Attending Physician Statement - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion
>6 MOS-44 with current coverage	Telephone Interview - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion
19-39: <i>Cases with no ratable conditions**</i> with no current coverage	Paramedical Examination Required Telephone Interview - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion
19-39: <i>Cases with no ratable conditions**</i> with current coverage	Telephone Interview Required Paramedical Examination - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion
45-54	Telephone Interview Required Attending Physician Statement - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion
55-64	Attending Physician Statement Required Telephone Interview - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion
ADULT BUILD <i>Greater than the standard weight stated in the height-weight chart, and therefore may result in a surcharge</i>	Telephone Interview - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion
CV, LIPID HX	Telephone Interview Required Paramedical Examination - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion

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AGE	REQUIREMENT*
SMOKER <i>Individual with intake of nicotine in the 12 months preceding application date.</i>	Telephone Interview Required Paramedical Examination - Underwriter's Discretion Attending Physician Statement - Underwriter's Discretion
NON-REPL BUSINESS	Telephone Interview Required Attending Physician Statement - Underwriter's Discretion Paramedical Examination - Underwriter's Discretion
NON-CITIZEN BUSINESS	Telephone Interview Required Paramedical Examination Required Attending Physician Statement - Underwriter's Discretion
OBESITY RIDER	Paramedical Examination Required Telephone Interview Required Attending Physician Statement Required

* Any and/or all underwriting requirements are Underwriter discretionary to manage and meet the accountability and expectations of product-line financial responsibility.

** Standard rate that is applicable for smoker base premium or for non-smoker base premium.

19- Underwriting Phone Interviews

After reviewing an application, the Underwriter may require a phone interview with the applicant. This process, ***when conducted with contracted professional interviewers***, can be completed in approximately 10-15 minutes. In most situations, the information acquired in the interview is sufficient for underwriting to complete their selection review process. Please refer to the Underwriting Requirements section (17) for a guideline of when a telephone interview is required.

20- Underwriting Paramedical Examinations

Paramedical examinations allow an insurance carrier to collect medical risk factor data. The insurance carrier pays for the cost of this service. Normally the carrier contracts with a company that specializes in collecting data and performing tests. A nurse or medical assistant from the selected company will contact the insurance applicant to arrange a paramedical exam appointment. The exam lasts approximately 15-20 minutes and, in most cases, consists of measuring the applicant's height, weight, and blood pressure and requires a urine sample. Applicants must have proof of identification at the exam. Upon completion, samples are sent to a lab that provides test results to the underwriting department. This process may take 3-5 business days. Underwriting uses this data to assist in determining whether to accept, rate up or decline an individual for coverage. Please refer to the Underwriting Requirements section (17) to determine when the paramedical exam is required.

21- Occupations That Are Unacceptable

- Actors & Actresses
- Air Traffic Employees
- Arcade Employees
- Armed Services
- Artist, Freelance
- Asbestos Workers
- Athletes – Professional and Semi Professional

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- Aviation – Requires Underwriter Review
- Bar or Pub Owners & Employees
- Carnival Workers
- Circus Workers
- Crop Dusters
- Detective
- Divers, Professional
- Dock Workers (Longshoreman)
- Drivers (Mining, Racing)
- Explosives Workers
- Firefighters
- Fishing Boat (crew and captain not returning to port each night)
- “Gentlemen’s Club” Owners & Employees
- Government Employees, State and Federal
- Guides, Hunter, Fishing and Mountain Climbing
- Halfway House Workers
- Iron Workers (except ornamental Iron Workers)
- Jockeys
- Loggers
- Logging Truck Drivers
- Migrant Workers
- Mill Workers
- Miners
- Models, Professional
- Musicians (except symphony orchestra performers)
- Oil Rig Workers and Offshore Drillers
- Packing and Slaughterhouse Workers
- Police
- Prison Employees
- Prisoners
- Pyrotechnist
- Quarry Workers
- Reporters, Freelance
- Rodeo Participants, Professional
- Roofers
- Sheriffs
- Structural Steel Workers
- Toxic Chemical Workers
- Trappers
- Tunnel and Caisson Workers
- Window Cleaners (Working at heights in excess of three stories)

22- Medical Condition Guidelines

Note: This list is not all-inclusive and is subject to change at Underwriter discretion.

Rate Up Levels

20% 40% 60%
Tobacco 30%

Individuals with one or more medical conditions that exceed a 60% rate up will be declined for coverage (tobacco usage excluded) unless the individual is HIPAA eligible, then the rate up will be 4.98 times the base rate.

* = Additional information may likely be required, which could mean a higher rate up. Choosing a higher deductible may result in lower percentage rate up.

Condition	U/W Factors (From Application Receipt Date)	U/W Rating
Acid Reflux	See GERD	
Acne	Mild-No Prescription Medication Treated with Prescription Medication	Standard Rate 20% *
Addison’s Disease		Decline

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ADHD	Under 17 years	*
	Over 17 years	20%
Adjustment Disorders-Mild	Within 1 Year	20%
	Over 1 Year	Standard Rate
AIDS/HIV		Decline
Alcoholism	Within 7 Years	Decline
	8-12 Years	40%
	> 12 Years	Standard Rate
Allergies	Mild, no desensitization treatments	Standard Rate
	Attacks more severe than mild	40%
	Undergoing desensitization treatments	20% *
Anemia		Underwriter Review
Angina		Decline
Anorexia Nervosa, Bulimia Nervosa	Within 3 Years	Decline
	3-5 Years	60%
	> 5 Years	Standard Rate
Anxiety	Mild	20%
	Moderate	20% *
	Severe	Decline
Aortic Stenosis		Decline
Arthritis		
Osteoarthritis	Minimal	Standard Rate
	Moderate	40%
	Severe	Decline
Psoriatic, Rheumatoid		Decline
Artificial Limbs	Amputation or Disease	Decline
	Accident within 2 Years: Arm	20%
	Accident within 2 Years: Leg	40%
	Two Limbs	Decline
	Undergoing Psychotherapy or Physiotherapy	Decline
Asthma	Varies By Age and Type	Medical Questionnaire
Back Disorder		
Herniated/Bulging Disc	Unoperated	Decline
	Operated 0-3 Years	Decline
	Operated > 3 Years	Standard Rate
Back Sprain/Strain	Within 1 Year	20% *
	Over 1 Year	Standard Rate
Breast Cancer	0-5 Years	Decline
	>5 Years	Underwriter Review
Bipolar Disorder		Decline
Breast Disorders		
Breast Disease (not cancer)	Present	20%
	Diagnosis Uncertain	Decline
Breast Implants	Present	20%
	Present-Need Removal	Decline
	Complications	Decline
Bronchitis (pulmonary function test results needed)		
Chronic		
Non Smoker – with spirometry results		40%
Smoker		Decline
Acute: 1-2 attacks per year		Standard Rate

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Cancer			
	Leukemia		Decline
	Lymphoma, Non-Hodgkins		Decline
	Multiple Myeloma		Decline
	Melanoma		
	Present (0-5 Years)		Decline
	Removed, Recovered, and Benign (>5 Years)		Standard Rate
Carpal Tunnel Syndrome			
	Mild, No surgery anticipated	0 – 1 Year	*
		> 1 Year	Standard Rate
Cataract		Operated: Within 1 Year	*
		Over 1 Year	Standard Rate
		Unoperated	*
Cervicitis		Present	Decline
		1 Episode, Recovered	Standard Rate
		Recurrent Episodes	Medical Questionnaire
Cholesterol		< 250	Standard Rate
		250-275	20%
		276-299	40%
		>300	Decline
Chronic Obstructive Pulmonary Disease			Decline
Corneal Ulcer		Present	Decline
		Recovered	Standard Rate
Crohn's Disease			
	1 Attack	0-5 Years	Decline
		5-10 Years	60% *
		> 10 Years	Standard Rate
	Multiple Attacks	0-10 Years	Decline
		> 10 Years	60% *
Cystitis		Acute Mild Attacks	Standard Rate
		Chronic 0-2 years	Decline
Dementia			Decline
Depression			
	Major	0-5 years from Recovery	Decline
		5-10 years from Recovery	40%
		>10 years from Recovery	Standard Rate
	Mild	0-2 years from Recovery	Decline
		2-4 years from Recovery	40%
		>4 years from Recovery	Standard Rate
	Situational	Present to 1 Year afterward	20% *
Deviated Nasal Septum		Operated	Standard Rate
		Unoperated & Asymptomatic	20%
Diabetes Mellitus			Decline
Dislocations			
	Knee or Hip	Operated: Within 3 Years	Decline
		Over 3 Years	Standard Rate
		Unoperated	Decline
	Ankle, Foot, Elbow, Wrist	Within 3 Months	Decline
		Over 3 Months	Standard Rate

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Diverticulitis Unoperated	Present	Decline
	1 attack, recovered 0-2 years	40%
	1 attack, recovered >2 years	Standard Rate
Operated	Multiple attacks	Decline
	0-2 Years	40%
	> 2 years	Standard Rate
DUI – Single Offense		
Under Age 25	0-1 Year	Decline
	1-3 Years	Decline
	> 3 Years	Standard Rate
Age 25 and older	0-1 Years	Decline
	1-3 Years	40%
	> 3 Years	Standard Rate
Drugs, Illegal	Within 7 Years	Decline
	Over 7 Years	Standard Rate
Emphysema	Non Smoker with spirometry results	Questionnaire + 40%
	Smoker	Decline
Endometriosis	Unoperated	Decline
	Operated	20%
Epilepsy	Dependent on type of seizures	Questionnaire
Fibromyalgia		
Present	Mild	20% *
	Other	Decline
Recovered	Mild, 0-2 Years	20% *
	Mild, > 2 Years	Standard Rate
	Other, 0-3 Years	Decline
	> 3 Years	Standard Rate
Fracture (wrist, arm, leg, shoulder, ankle)	Present	Decline
	Recovered 0-3 Months	Decline
	Recovered > 3 Months	Standard Rate
	Fixation devices still present	40% *
Gallbladder Disorders		
Cholelithiasis or Cholecystitis	Operated: Fully Recovered	Standard Rate
	Not Fully Recovered	Decline
	Unoperated	Decline
Other		Underwriter Review
Gastric Bypass	0 – 3 Years	Decline
	3 – 8 Years	60%
	> 8 Years	Standard Rate
Genital Warts	Present	Decline
	Multiple episodes after recovery 0-2 Years	Decline
	> 2 Years	Standard Rate
GERD	Mild attacks, no prescription medication	Standard Rate
	All Others	*
Gestational Diabetes	Current Pregnancy	Decline
	Past Pregnancy	
	Over Age 45	Standard Rate
	Under Age 45 with complications	40%
Glaucoma	Controlled with medications	20% *
	Poor control or deterioration	Decline

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Gonorrhea		
1 Episode	0-6 Months	Decline
	> 6 Months	Standard Rate
> 1 Episode	0-2 years	Decline
	> 2 years	Standard Rate
Gout		
Underwriter Review		
Headache (Migraine)		
	Mild, Occasional	Standard Rate
	Severe or Frequent	20% *
	Recent Onset, No Evaluation	Decline
Heart Disorders		
Heart Attack		
		Decline
Atrial Fibrillation & Flutter		
	Within 3 Years	Questionnaire
	Over 3 Years	Standard Rate
Coronary Artery Disease, Coronary Heart Disease		
		Decline
Coronary Angioplasty		
		Decline
Congestive Heart Failure		
		Decline
Coronary or vascular stent, Pacemaker		
		Decline
Mitral Valve Prolapse		
		Underwriter Review
Palpitations/Cardiac Murmurs		
		Underwriter Review
Rapid Heart Rate (Tachycardia)		
		Underwriter Review
Hematuria (Cause Unknown)		
	1-10 cells	Standard Rate
	> 10 cells	Decline
Hemiplegia		
Decline		
Hemophilia		
Decline		
Hemorrhoids		
	Operated, Recovered	Standard Rate
	Unoperated	*
Hepatitis		
Type A or E		
	Within 6 Months	Decline
	Over 6 Months	Standard Rate
Type B/D		
	Within 1 Year	Decline
	Over 1 Year	Underwriter Review
Type C/G		
		Decline
Alcoholic		
		Decline
Chronic		
		Decline
Hernia		
Operated:		
	Recovered, No GERD	Standard Rate
	Recovered, GERD Present	*
Unoperated		
		Decline
Herpes (Genital)		
	0-6 Months	Decline
	> 6 Months	*
Hodgkin's Disease		
	Within 10 Years	Decline
	10-15 Years	60%
	15-20 Years	20%
Hypertension		
	Controlled by Medication	Underwriter Review
		20%
Hypoglycemia (low blood sugar)		
	= > 45 mg/dl	Standard Rate
	Fasting < 45 mg/dl	Decline
Hypotension (low blood pressure)		
	No Symptoms	Standard Rate
	With Symptoms	Decline

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Irritable Bowel Syndrome	Mild		
	0-1 Year	20% *	
	> 1 Year	Standard Rate	
	Recurrent Attacks		
	0-3 Years	20% *	
	> 3 Years	Standard Rate	
	Jaw Disorders		
	TMJ		
	Pending Surgery	Decline	
	No Treatment	Standard Rate	
	Mouthpiece	Standard Rate	
	Unoperated	Standard Rate	
Joint Replacement (i.e. hip, knee)		Decline	
Kidney Stones	Present	Decline	
	1 attack 0-3 years	20% *	
	1 attack >3 years	Standard Rate	
	2 or more 0- 5 years	40% *	
	2 or more > 5 years	Standard Rate	
Leukemia		Decline	
Lupus			
	Discoid	1 year treatment free	40%
	Systematic		Decline
Mental Retardation		Decline	
Multiple Sclerosis		Decline	
Muscular Dystrophy		Decline	
Osteoporosis	Severe	Decline	
	Other	40%	
Otitis Media (Acute)	0-2 episodes per year	Standard Rate	
	> 2 episodes in 1 year	*	
	Tympanostomy tubes in place	*	
	Pancreatitis (Acute)		
One Attack	0-1 Year	Decline	
	1-3 Years	40%	
	> 3 Years	Standard Rate	
	More than One Attack		
	0-5 Years	Decline	
	5-8 Years	40%	
	> 8 Years	Standard Rate	
Panic Disorder	See Anxiety		
Pap Smear (Abnormal)		Questionnaire	
Paraplegia		Decline	
Parkinson's Disease		Decline	
Polyp (Colon)		Questionnaire	
Post-Menopausal Bleeding	Within 2 Years	Decline	
	After 2 Years	Standard Rate	
Pregnancy	Present	Decline	
	4 weeks post-partum	Standard Rate	
Prostatic Hypertrophy		Questionnaire	

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Prostatitis	Present	Decline
Acute	Acute	Standard Rate
	Chronic - Within 3 Years	40% *
	Chronic - Over 3 Years	Standard Rate
Psoriasis	Mild	Standard Rate
	All others with normal liver enzymes and no nail involvement	20% *
Quadriplegia		Decline
Raynaud's Disease	Mild	Standard Rate
	Severe	Decline
Renal Failure		
Acute	Present – 1 Year	Decline
	> 1 Year	Standard Rate
Chronic		Decline
Restless Leg Syndrome	Mild	20% *
	Severe	Decline
Retinal Detachment	Unoperated	Decline
	Operated	
	Within 3 years	20% *
	Over 3 years	Standard Rate
Schizophrenic Disorders		Decline
Sinusitis		
Acute	< 3 attacks per year	Standard Rate
Chronic	>3 attacks per year, No Surgery Advised	40%
	>3 attacks per year, Surgery Advised	Decline
Sleep Apnea	Operated	
	Full Recovery	Standard Rate
	Undergoing Treatment	Decline
	Unoperated	
	CPAP-N-CPAP	20% *
Stroke		Decline
Thyroid Gland Disorders	Untreated	Decline
	Adequately Treated	Standard Rate
Tonsillitis	Operated	Standard Rate
	Unoperated	
	< 5 episodes, none in prior year	*
	5 or more episodes, none in prior year	Decline
Ulcer		Underwriter Review
Ulcerative Colitis	Unoperated	Underwriter Review
	Operated	
	0-2 Years	Decline
	> 2 Years	60% *
Uterine Fibroids	Operated	Standard Rate

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23-26- Height\Weight Charts

Male Weight Chart Lbs (age 16-64)						
BMI	18Kg/M2	32Kg/M2	34Kg/M2	36Kg/M2	37Kg/M2	>37Kg/M2
Height	Decline Underweight	STD Max	20% Max	40% Max	60% Max	Decline Overweight
4' 11"	96	158	170	179	186	187
5' 0"	98	164	174	184	190	191
5' 1"	100	169	180	190	196	197
5' 2"	102	175	186	197	202	203
5' 3"	104	180	192	203	209	210
5' 4"	106	186	198	210	215	216
5' 5"	108	192	205	217	224	225
5' 6"	112	198	211	223	230	231
5' 7"	115	204	218	230	236	237
5' 8"	118	210	224	237	244	245
5' 9"	122	217	230	244	250	251
5' 10"	126	223	234	250	258	259
5' 11"	130	230	244	258	265	266
6' 0"	133	235	250	265	272	273
6' 1"	136	242	258	274	280	281
6' 2"	140	250	265	280	288	289
6' 3"	144	256	272	288	295	296
6' 4"	148	264	280	295	304	305
6' 5"	152	270	286	304	312	313
6' 6"	156	278	295	312	320	321
6' 7"	160	285	302	320	328	329
6' 8"	164	291	310	328	337	338

Female Weight Chart Lbs (age 16-64)						
BMI	18Kg/M2	32Kg/M2	34Kg/M2	36Kg/M2	37Kg/M2	>37Kg/M2
Height	Decline Underweight	STD Max	20% Max	40% Max	60% Max	Decline Overweight
4' 10"	90	147	161	170	174	175
4' 11"	92	153	166	176	180	181
5' 0"	94	157	172	182	187	188
5' 1"	96	163	178	188	193	194
5' 2"	98	167	183	194	199	200
5' 3"	100	174	189	200	206	207
5' 4"	102	181	195	207	213	214
5' 5"	104	185	201	214	220	221
5' 6"	108	192	208	220	226	227
5' 7"	110	196	214	226	233	234
5' 8"	113	203	220	233	240	241
5' 9"	117	209	227	240	247	248

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Female Weight Chart Lbs (age 16-64)						
BMI	18Kg/M2	32Kg/M2	34Kg/M2	36Kg/M2	37Kg/M2	>37Kg/M2
Height	Decline Underweight	STD Max	20% Max	40% Max	60% Max	Decline Overweight
5' 10"	121	215	234	247	254	255
5' 11"	125	220	240	255	262	263
6' 0"	128	228	247	262	269	270
6' 1"	131	232	254	268	277	278
6' 2"	134	240	262	276	284	285
6' 3"	138	248	268	284	292	293
6' 4"	142	253	275	292	300	301

Children outside of the height/weight range charts that follow may require additional information to be considered for coverage.

Infants (Birth through age 3)		
Age	Height (Inches)	Weight (Lbs.)
Birth	18 - 22	5 - 10
1 Month	19 - 23	6 - 12
2 Months	20 - 24	8 - 13
3 Months	21 - 25	9 - 16
4 Months	22 - 26	11 - 18
5 Months	23 - 28	13 - 20
6 - 9 Months	24 - 30	14 - 25
9 - 12 Months	26 - 32	15 - 27
12 - 15 Months	27 - 34	17 - 29
15 - 18 Months	29 - 35	19 - 32
18 - 21 Months	30 - 36	21 - 34
21 - 24 Months	31 - 37	22 - 35
24 - 27 Months	31 - 38	22 - 36
27 - 30 Months	32 - 39	23 - 37
30 - 33 Months	33 - 40	24 - 39
33 - 36 Months	33 - 41	25 - 40

Children (4 - 8)		
Age	Height (Inches)	Weight (Lbs.)
3 - 4 Years	34 - 43	28 - 46
4 - 5 Years	38 - 46	32 - 52
5 - 6 Years	40 - 49	35 - 59
6 - 7 Years	42 - 51	39 - 66
7 - 8 Years	44 - 54	42 - 74

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Children (9 - 11)		
Height (Feet)	Height (Inches)	Weight (Lbs.)
3' 10"	46"	40 - 60
3'11"	47"	42 - 64
4'0"	48"	43 - 70
4'1"	49"	45 - 75
4'2"	50"	47 - 85
4'3"	51"	50 - 90
4'4"	52"	53 - 94
4'5"	53"	56 - 98
4'6"	54"	60 - 103
4'7"	55"	63 - 110
4'8"	56"	66 - 117
4'9"	57"	69 - 127
4'10"	58"	72 - 136
4'11"	59"	74 - 144
5'0"	60"	77 - 152
5'1"	61"	79 - 163
5'2"	62"	82 - 168
5'3'	63"	86 - 173

Children (12 - 15)		
Height (Feet)	Height (Inches)	Weight (Lbs.)
4'4"	52"	62 - 90
4'5"	53"	66 - 95
4'6"	54"	70 - 97
4'7"	55"	72 - 107
4'8"	56"	74 - 115
4'9"	57"	76 - 124
4'10"	58"	80 - 128
4'11"	59"	83 - 132
5'0"	60"	84 - 137
5'1"	61"	87 - 140
5'2"	62"	90 - 146
5'3'	63"	93 - 150
5'4"	64"	96 - 155
5'5"	65"	99 - 160
5'6"	66"	102 - 165
5'7"	67"	105 - 170
5'8"	68"	108 - 175
5'9"	69"	112 - 180
5'10"	70"	115 - 185
5'11"	71"	118 - 190
6'0"	72"	122 - 196
6'1"	73"	125 - 202

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27- Tobacco Use Rates

Tobacco use is a criteria that underwriting uses to assign a higher premium. The insurance application requires the primary applicant or spouse to state whether he or she has **used tobacco in the past twelve months**. An applicant who responds “yes” is assigned a higher premium. A “no” that is later determined should have been a “yes” will be handled as a misrepresentation and the premium will be adjusted accordingly. Any request to change from a smoker classification to a non-smoker classification must be after a twelve (12) month cessation period (dated from the last tobacco intake) and require a lab test as proof of tobacco cessation – any costs for the lab work is the member’s responsibility.

28- Medications

A list of covered medications may be obtained online at optimahealth.com under our searchable drug list. From the drug list, select “Generic Plus” for prescriptions covered under the Individual and Family Plans. Members who have been prescribed a medication that is not currently covered may have their physician submit an authorization form for exception. Forms can be found online, by calling Member Services or through your representative.

With regards to new applications, the following is a list of medications that are normally associated with a chronic medical illness. These medications and the associated treatment are often grounds for denial of coverage. This list is not an all-inclusive list, nor is it a list that in all situations automatically disqualifies an individual.

Medications Normally Prompting Non-Acceptance:

Abacavir	Cibalith-S	Emtriva	HIVID
Abilify	Cisplatin	Enbrel	Humira
Aggrenox	Clolar	Entocort	Hyalgan
Aldurazyme	Clozapine	Epivir	Indinavir
Alimta	Clozaril	Epzicom	Insulin
Amprenavir	Cognex	Equetro	Interferon
Antabuse	Combivir	Erbitux	Invirase
Apokyn	Comtan	Eskalith	Iressa
Arava	Crizivan	Fabrazyme	Kaletra
Aricept	Cyclosporine	Faslodex	LAAM
Aromasin	Cytovene	Fazaclor	Lamivudine
Avastin	d4T	Felbamate	Leponex
Avonex	Dapsone	Felbatol	Levomethadyl
AZT	Daunoxome	Flolan	Lexiva
Baraclude	Delavirdine	Fortovase	Lithane
Betaseron	Didanosine	Foscavir	Lithium
Bexxar	Doxil	Fuzeon	Lithizine
Campral	Duralith	Ganciclovir	Lithobid
Capoxone	Efavirenz	Geodon	Lithonate
Carbolith	Eloxatin	Gleevec	Lithotabs

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Lymphocyte	Platinol	Suboxone	Tysabri
Immune Globulin	Plavix	Subutex	Valcyte
MBACOD	Plenaxis	Supartz	Vantas
Memantine	Pletal	Sustiva	Velcade
Mepron	PMPA	Symbyax	Vidaza
Methadone	Pneumonpent	Symlin	Videx
Methotrexate	Prialt	Synagis	Viracept
Muromonab-CD3	Rebif	Synvisc	Viramune
Mycophenolate	Remicade	Tacrolimus	Voread
Myfortic	Rescriptor	Tarceva	Vistide
Namenda	Retrovir	Tasar	Vitravene
Naltrexone	ReVia	Taxotere	Zalcitabine
Neupogen	Reyataz	Thalidomide	Zerit
Norvir	Risperdal	Thalomid	Ziagen
Octagam	Sandimmune	Ticlid	Zidovudine
Orthoclone OKT3	Seroquel	Ticlopidine	Zyprexa
Parcopa	Somavert	Trizivir	
Pentamidine	Stavudine	Truvada	

29- Appeals of Underwriting Decisions

Applicant Appeals must be submitted in writing to Optima Health. Appeals asking for reconsideration of an adverse underwriting decision are to be mailed to Appeals, Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462. The letter should display an explanation for reconsideration. It is the responsibility of the applicant to provide documentation to support the reconsideration request. This documentation needs to be supported by medical records from the pertinent physician familiar with the applicant's case. The results of any and all testing, lab results, pathology, and medically recognized diagnostic testing methods should also be included.

Virginia state law identifies that appeals must be submitted in writing within 90 business days of the date the applicant receives notice of our underwriting decision. Upon receipt of the applicant's reconsideration request, an Underwriter will conduct research to determine all facts surrounding the decision in question.

At conclusion of the review, a timely decision will be made and communicated to the applicant. The Underwriter may either substantiate that the original decision stands or decide to overturn the original decision. For overturned or reversed underwriting decisions, the applicant may be required to complete a new application. It is also important to remember that our underwriting guidelines are time-specific. Therefore, an underwriting decision may vary depending on the time the decision was made. Underwriting actions and dispositions align to the underwriting guidelines in effect at that time.

Our underwriting decision is based on the individual's health status at the time the application is received until the application process has been completed. It is important to keep in mind that additional information may be requested for other conditions that have not yet been investigated and therefore impact any final decision made by Optima Health underwriting.

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30- When Change of Benefits Can Possibly Occur

Our rule is that one benefit change per year can be made 90 days or more after the effective date of the contract or upon benefit renewal. Changes can also occur as a result of a “qualifying event.” Examples of qualifying events are: marriage, divorce or legal separation; adding or deleting a dependent; birth or adoption; the end of the year in which a dependent child turns 26; beginning active duty with the Armed Services; reaching age 65 or becoming eligible for Medicare; death of a covered person; a covered policyholder or spouse who is changing or losing their job; and fulfillment of a court order.

Changes become effective the first of the month following notification and/or receipt of the request, unless the circumstances dictate otherwise (e.g. dictates of policy language, stipulates of regulatory authority, or court directed decrees, etc.).

31- Virginia Mandated Optional Benefits

We have three optional benefits that we are required to offer with our Optima Health Individual Plan. They are the Morbid Obesity Treatment Rider, the Child Health Supervision Services Rider, and the Prosthetic Devices and Components Rider. Riders can only be added or deleted upon initial enrollment, with a qualifying event or at renewal. The following information separately recaps the benefits and services offered by these three riders.

31.1- Morbid Obesity Treatment Rider

This Rider provides benefits and coverage for treatment of morbid obesity using gastric bypass surgery or other such methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Once the morbid obesity rider has been chosen, it can not be dropped from coverage until the next renewal period.

Morbid Obesity means a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables; a body mass index equal to or greater than 35 kilograms per meter squared with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or a body mass index of 40 kilograms per meter squared without such co-morbidity. As used herein, body mass index equals weight in kilograms divided by height in meters squared.

It is the member’s responsibility for all applicable In-Network or Out-of-Network copayments, coinsurances and /or deductibles. The member’s cost toward services depends on the type of service and where the service is rendered.

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31.2- Child Health Supervision Services Rider

The Child Health Supervision Services Rider provides periodic examination coverage for dependent children of the policy. Child health supervision services means the periodic review of a child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. Benefits for child health supervision services will be provided at approximately the following age intervals: **birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years.** Benefits provided by this rider **do not require any copayment, coinsurance, deductible, or other dollar limit** provision stated in the policy or collateral schedule.

31.3- Prosthetic Devices and Components Rider

The Prosthetic Devices and Components Rider adds coverage for Prosthetic Devices. Coverage also includes repair, fitting, replacement, and components. All services must be Medically Necessary. Pre-Authorization is required for all services.

32- What Does HIPAA Eligible Mean?

An individual that meets the definition prescribed by the Health Insurance Portability and Accountability Act. That definition can best be stated here by stating the guidelines specified by the Act as follows:

An individual,

For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen or more months and whose most recent prior creditable coverage was under individual health insurance coverage, a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan;

Who is not eligible for coverage under a group health plan part A or part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act, or any successor program, and does not have other health insurance coverage;

Whose most recent coverage was not terminated based on the individual having failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer having not received timely premium payments or the individual having performed an act or practice that constitutes fraud or having made an intentional misrepresentation of material fact under the terms of the coverage;

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Who elected, if offered, the option of continuation of coverage under a COBRA continuation provision, or under a similar state program, and has exhausted such continuation coverage; and

In the case where individual health insurance coverage is the most recent creditable coverage, the coverage was nonrenewed by the health insurance issuer due to discontinuance of all coverage in the individual market in the Commonwealth, the aggregate period of creditable coverage required is reduced to twelve months.

For the purposes of determining the aggregate of the periods of creditable coverage, a period of creditable coverage will not be counted with respect to enrollment of an individual under a health benefit plan if, after such period, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period.

33- Federal Mandated HIPAA Individual Benefits

HIPAA eligible individuals applying for coverage can so indicate their status and elect to be subjected to evidence of insurability or not. This status individual can be processed for benefits like any other NON-HIPAA eligible individual. If this individual fails to pass the evidence of insurability qualifier, he/she can still obtain HIPAA eligible guaranteed coverage once evidence of their eligibility status is presented to underwriting. As a HIPAA eligible individual, the individual is not subjected to any evidence of insurability and any pre-existing condition exclusion waiting period is waived. To qualify as a HIPAA eligible individual, one must give notification that they are HIPAA eligible and provide documentation that substantiates that they meet **all** of the following requirements:

- ✓ Has had at least 18 months of prior creditable coverage without a break of more than 63 days without any coverage or without being in a waiting period for coverage*; **And**
- ✓ most recent coverage must have been under individual health insurance coverage, a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan; **And**
- ✓ most recent coverage can not have been terminated for non-payment of premiums or fraud; **And**
- ✓ cannot have other health insurance coverage or be eligible for coverage under a group health plan, Medicare, or Medicaid; **And**
- ✓ has elected and exhausted cobra or similar state continuation of benefits coverage, if it was available to you.

Creditable coverage includes group health plans, qualifying health insurance coverage, Medicare, Medicaid, CHAMPUS/TRICARE, or other publicly sponsored programs. If your most recent creditable coverage is individual health insurance, and the insurer

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offering it has exited the individual health insurance market and canceled your coverage, then 12 months, not 18 months, of prior creditable coverage is required.

34- Military Opt-Out and Re-entry

Optima Health policyholders are given an opportunity, should they be a service area resident reservist, to continue or cancel coverage. If the policyholder elects to continue the policy, Optima Health will be primary and TRICARE will be secondary. However, if the policyholder elects to cancel the Optima Health policy, he/she will be allowed to re-enroll without being subjected to any underwriting within [the greater of two (2) years or the active duty period] of their initial activation date. The re-enrollment request must be received within 120 days of the discharge date and accompanied with a documented copy of the newly instituted inactive status. The policyholder will be offered re-entry benefits without any evidence of insurability requirement in a policy that is as close to the coverage issued prior to the opt out of the [disenrolled] canceled policy.

Reservists will receive portability credit for any time served under TRICARE as long as there is no more than a 120-day break in coverage and the re-enrollment guidelines are met. Any creditable coverage eligibility credit applicable to satisfying a pre-existing waiting period that has not been met will still be applicable and required to be satisfied once re-enrolled in new benefits.

Failure to request cancellation of dependent coverage along with the reservist request will disqualify any dependent for re-enrollment in the future on a guaranteed issue basis (evidence of insurability would be required).

35- Quoted Price Changes

The final rate provided by underwriting is determined by the applicant's medical history survey responses and any other correlated information. Assuming underwriting offers a given benefit for a given price, the initial price generated from the quoting system may vary significantly due to the application of underwriting changes. Optima Health has three defined premium adjusted classes in addition to the standard base premium for non-HIPAA eligible individuals. Optima Health also has one class for HIPAA eligible individuals. These classes represent different premium surcharges applied to a standard premium. Any changes to the pricing of the benefits will be noted to the applicant by system-generated communications. Underwriting will communicate the denial of any individual and arrange for approval of any other family member(s) who has concurrently applied for coverage.

36- What About Coverage During Pregnancy?

An individual who is pregnant is not eligible for coverage until completion of the pregnancy. Additionally, if an applicant's spouse, significant other or dependent is

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pregnant at the time of application, an application can not be accepted from any member of the family, due to potential risk of the unborn child.

37- What is Creditable Coverage?

Creditable coverage means coverage credit which may be applied to reduce all or part of the 12 month pre-existing condition exclusion period. A pre-existing condition means a condition (whether physical or mental) regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the Member's enrollment date. Creditable coverage means coverage of the individual under any of the following:

- A group health plan
- Health insurance coverage
- Part A or B of Title XVIII of the Social Security Act
- Title XIX of the Social Security Act other than coverage consisting solely of benefits under section 1928
- Chapter 55 of Title 10 United States Code
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- A health plan offered under Chapter 89 of Title 5, US Code
- A public health plan
- A health benefit plan under section 5 e of the Peace Corps Act
- Individual health insurance coverage

38- Broker Commission Schedule - Agents

The following applies to Optima Health's under 65 products. Agents/Brokers must be appointed to Optima Health before they can represent our products and receive compensation.

Individual Health Plan – Under Age 65	1 st year	Renewal
Optima Plus PPO	15%	9%
Optima Foursight PPO	15%	9%
Optima Equity (HSA)	15%	9%
All Plans when Maximum Rate is applied*	2%	1%

**Maximum rate factor applies to HIPAA eligible plans.*

For agent commission questions, please call Holly McGillvray at (757)552-7245.